Supreme Court, U.S.
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In the

Supreme Court of the United States.

OCTOBER TERM, 1994.

LIABILITY INVESTIGATIVE FUND EFFORT, INC.; LEONARD MORSE, M.D.; JUAN PENHOS, M.D.; WAYNE GLAZIER, M.D.; FRANCIS ROCKETT, M.D.; J. GORDON RICH, M.D.; AND JAMES BOYD, M.D.,
PETITIONERS,

v.

COMMONWEALTH OF MASSACHUSETTS, LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,
RESPONDENTS.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS.

PETITION FOR WRIT OF CERTIORARI.

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QUESTIONS PRESENTED.

I. Does the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premium deficits violate Petitioners' right to procedural due process?

II. Does an unconstitutional impairment of contract occur when a subsequently enacted statute is used to substantially alter the obligation of an existing contract of insurance?

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OPINIONS BELOW.

This Petition for a Writ of Certiorari ("Petition") seeks review of a judgment of the Supreme Judicial Court of the Com-

monwealth of Massachusetts which is reported at 418 Mass. 436 (1994). A complete copy of the decision is appended to this Petition.

STATEMENT OF JURISDICTION

The opinion of the Supreme Judicial Court of Massachusetts was rendered on July 21, 1994. This Court has jurisdiction under 28 U.S.C. § 1257(3).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

United States Constitution, Fourteenth Amendment:

Section 1. *** . . . nor shall any State deprive any person of life, liberty, or property, without due process of law. . . .

United States Constitution, Article I, § 10:

No State shall . . . pass any . . . Law impairing the Obligation of Contracts. . . .

Massachusetts St. 1975, c. 362, § 6, 7th paragraph:

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by an assessment upon the policyholders, or a rate increase applicable prospectively, or both; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Massachusetts St. 1980, c. 333.

Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by a rate increase applicable prospectively; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term "policyholders" shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not.

Massachusetts St. 1986, c. 351, § 38.

A copy of § 38 of Massachusetts St. c. 351 is appended to this Petition.

STATEMENT OF THE CASE

Prior to mid-1975, a free, albeit regulated, market for medical malpractice insurance existed in Massachusetts. Then, the Massachusetts Legislature created a Medical Malpractice Joint Underwriting Association of Massachusetts (the "JUA")[1] — an official state entity — which quickly became the only source of medical malpractice insurance for the vast majority of physicians in the Commonwealth.

The legislation provided that the JUA could, *inter alia*, "recoup" medical malpractice insurance premium "deficits" by an assessment on policyholders, or by a rate increase applicable prospectively, or both (St. 1975, c. 362, § 6, 7th paragraph).

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[1] The Medical Malpractice Joint Underwriting Association was subsequently renamed the Massachusetts Medical Professional Insurance Association.

In 1980, the Legislature modified the JUA's deficit recoupment power, restricting it only to "a rate increase applicable prospectively," the intent of that legislation being to prohibit the previously allowed retroactive assessments (St. 1980, c. 333).

In June 1986, pursuant to the power to recoup deficits purportedly granted by the 1975 statute, the Commissioner of Insurance imposed on the Commonwealth's physicians, including Petitioners, a retroactive medical malpractice insurance premium recoupment of an additional 51.9% for the period July 1, 1983 – June 30, 1984. Also in June 1986, the Commissioner imposed a retroactive premium recoupment of an additional 68.4% for the period July 1, 1984 – June 30, 1985. Both recoupments cumulatively represented *pre-existing medical malpractice insurance premium deficits* of approximately *$200,000,000*. Later that same month, the Legislature enacted yet another statute relating to medical malpractice insurance premiums, St. 1986, c. 351. *Inter alia*, this statute labeled the $200,000,000 shortfall in medical malpractice insurance premiums for the 1983 – 1984 and 1984 – 1985 periods — the "deficits" which the Commissioner had ordered "recouped" — as "deferred premium liability."[2]

Less than a year later, in April 1987, the JUA initiated an administrative proceeding before the Commissioner of Insurance, which continues even now, seeking to recoup from Petitioners and other of the Commonwealth's physicians even

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[2] *Inter alia*, that legislation labeled the $200,000,000 shortfall in medical malpractice insurance premiums — the "deficits" which the Commissioner ordered be "recouped" — as "deferred premium liability." It should be noted, however, that the $200,000,000 represented the recoupment of medical malpractice insurance premiums deficits which had *pre-existed* the Commissioner's June 6, 1986, determination that they were due, which had *pre-existed* the June 23, 1986, legislation, and which had *pre-existed* that legislation's characterization of the premium deficits to be recouped as "deferred premium liability." In other words, since an existing $200,000,000 "deficit" was being "recouped," *the legislation's "deferred premium liability"* characterization was merely a matter of nomenclature, nothing more.

more alleged medical malpractice insurance premium deficits, this time for the years *1975-1982* inclusive, and this time in the amount of approximately *$140,000,000*.

It is worth noting that the alleged insurance coverage that Petitioners and the other physicians in Massachusetts have received from the JUA beginning in 1975 has been in no real sense insurance. Their protection has been ephemeral. Normally, insurance carriers charge a current premium against their actuarialy-determined financial risk, their operating expenses, and their profit. If their projections are correct, they make money. If their calculations prove to have been wrong, they lose money. But, normally, insurance carriers cannot go back into the past and "recoup" sums that they have lost due to their mistaken actuarial calculations. That risk-taking is what the business of insurance is all about. However, because of the Massachusetts statutory provision allowing for deficit "recoupment," the JUA's underlying insurance carriers have been allowed to go back in time and obtain a correction of their underwriting mistakes and reimbursement of their underwriting losses. In other words, the carriers' underwriting mistakes have been only *temporary*, which is not the business of insurance. Even worse, the deficit recoupment power forces *the very persons who are supposed to have been insured, Petitioners and the other physicians in the Commonwealth of Massachusetts*, to make whole their supposed insurers. Because of the deficit recoupment power of the JUA, as written and as applied in a long-delayed fashion, Petitioners and the others *have been made de facto reinsurers of their own liability. They have been made sureties of their own insurance carriers' underwriting mistakes*.

In May, 1989 the Petitioners filed a complaint in the Massachusetts Superior Court challenging the constitutionality of St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, and St. 1986, c. 351. The complaint alleged that these statutes violated

the Contract Clause of the United States Constitution and the procedural due process guarantees of the United States Constitution. Both petitioners and respondents moved for summary judgment in the Massachusetts Superior Court. The Superior Court denied petitioners' motion and granted defendants' motions. The petitioners appealed and the Supreme Judicial Court of Massachusetts granted petitioners' application for direct appellate review.

The Supreme Judicial Court of the Commonwealth of Massachusetts rejected Petitioners' procedural due process and Contract Clause challenges to the constitutionality of the deficit recoupment power as written and as applied.

REASONS FOR GRANTING THE WRIT

I. PROCEDURAL DUE PROCESS

The first question presented by this Petition for a Writ of Certiorari is whether the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premium deficits violates the Petitioners' right to procedural due process. The question arises because Massachusetts law vested the Commissioner of Insurance with the power to go back in time and retroactively levy huge assessments against Petitioners and most other physicians in Massachusetts, and because that power has already been exercised at an actual and potential cost of hundreds of millions of dollars.

These huge costs are for physician-patient transactions which occurred in the past. There is not now, nor will there ever be, any possible way that Petitioners can recapture their portion of these sums from their *past* medical practices. Raising future fees is not an answer; they can do that quite apart from their need to be made whole as a result of the retroactive deficit recoupment premium payments. But what Petitioners cannot do

is to enter a time warp, and return to yesteryear. Petitioners cannot *now* raise their *past* fees for services rendered *then*, in an effort to retrieve expenses which only *now* they have learned from the Commissioner and the JUA that they had *then*.

In other words, Petitioners are being heavily burdened in the *present* for transactions which occurred in the *past*, and it is the importance of this issue that argues for grant of the Petition.

The case of *Railroad Retirement Board* v. *Alton*, 295 U.S. 330 (1935) is instructive in this regard. There, a federal law required interstate railroads to establish pension funds for its employees. Coverage was to include certain former railroad workers. In voiding the statute on procedural due process grounds, this Court emphasized the unconstitutionality of imposing "for the future a burden never contemplated by either party. . . . *** the provision . . . [imposes] new burdens [for] transactions long since past and closed. . . ." That is exactly what has happened to the Petitioners here.

In *Smith* v. *Illinois Bell Telephone Co.*, 270 U.S. 587 (1926), the telephone company was steadily losing money. As the law required, the company filed a proposed schedule of increased rates with the regulatory agency. Those rates, if allowed to go into effect, would have helped eliminate, or at least reduce, the ever-increasing deficits. For over three years the Illinois Commerce Commission failed to approve or disapprove the telephone company's proposed rate increases, thereby significantly worsening the company's eroding financial position. As Justice Sutherland said:

> . . . the commission for a period of two years remained practically dormant, and nothing in the circumstances suggests that it had any intention of going further with the matter. For this apparent neglect on the part of the commission, no reason or excuse has

> been given; and it is just to say that, without explanation, its conduct evinces an entire lack of that acute appreciation of justice which should characterize a tribunal charged with the delicate and important duty of regulating the rates of a public utility with fairness to its patrons, but with a hand quick to preserve it from confiscation.

Smith, supra at 590-91.

In other words, up to this point in its opinion the Court was saying, at the very least, that a state ratemaking body had an affirmative obligation, *constitutional in nature*, to prevent confiscation of the regulatee's assets (there, the telephone company's).[3]

But much more important for present purposes was what Justice Sutherland wrote for a unanimous Court, expressly concerning *the constitutionality of delay in ratemaking:*

> Property may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them; and where, in that respect, such a state of facts is disclosed as we have here, the injured public service company is not required indefinitely to await a decision of the rate-making tribunal. . . .

Smith, supra at 591.

Thus did this Court recognize not only that a state ratemaking body had a general constitutional duty not to confiscate a regulatee's assets by setting inadequate rates, but that *delay in terminating* confiscatorily inadequate rates could also violate constitutional rights.

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[3] It is of no constitutional significance that in *Smith* the ratemaker was the Illinois Commerce Commission, and in Massachusetts it is the Commissioner of Insurance.

Admittedly, neither of these inadequate rate situations is what confronts the Petitioners here. The Commonwealth has neither *set* rates so low as to constitute confiscation due to lack of an adequate return, or through delay allowed confiscatorily inadequate rates to remain in place. Instead, the Commonwealth has done what is arguably worse: *by means of an extreme, unexplained delay it has retroactively imposed excessive rates*. In principle, there is no meaningful difference between rates which are so low as to be confiscatory, and insurance premiums which are so excessive as to be confiscatory.

Thus, the common denominator between the heart of this Court's ruling in *Smith* v. *Illinois Commerce Commission*, and what the Commonwealth of Massachusetts has done to Petitioners here, is the *delay*. In *Smith* this Court said that prejudicial ratemaking (whatever the exact nature of the harm) resulting from inordinate (there, a mere two-year) *delay*, violated constitutional rights. Manifestly, what has happened to the Petitioners here is extremely prejudicial, and it, too, has been caused by a much longer *delay*, indeed, nearly as much as two decades. Thus, the question presented by this Petition is whether, under *Alton* and *Smith*, the textual and exercised power of a state administrative agency to retroactively recoup deficit medical malpractice insurance premiums is prohibited by the same constitutional principles enunciated by this Court in those cases, particularly with regard to settled expectations (*Alton*) and excessive delay (*Smith*).

II. CONTRACT CLAUSE

The second question presented by this Petition for a Writ of Certiorari is whether an unconstitutional impairment of contract occurs when a subsequently enacted statute is used to substantially alter the obligation of an existing contract of insurance. The question arises because under the original 1975

deficit recoupment statute, the JUA was *authorized* — but not required — to recoup medical malpractice insurance premium deficits by making "assessments" on policyholders, by promulgating rate increases to be applicable prospectively, or by both. *Statutorily*, the JUA was given these choices *when obligating itself, and when dealing with and obligating Petitioners*. In the very first contract/policies that the JUA issued, it exercised that choice. In those contracts/policies, the JUA made a conscious decision *textually* to reserve to itself the power to recoup *only* by means of "*assessments*." In other words, when the JUA entered into binding contractual insurance policy agreements with Petitioners immediately following enactment of the 1975 legislation, an essential term of those contracts/policies was the *method* by which, and the *pool* from which, the JUA would collect, and Petitioners pay, deficits which might later be recouped. As the contracts/policies themselves plainly show, that method was via assessments, and *only* via assessments, and the pool from which those assessments were to be drawn was the "*policyholders*." Thus, from 1975 to 1980 both parties to the contracts/policies of insurance — the JUA and its insured physicians, Petitioners here — were contractually bound to the recoupment of deficits *only* by means of assessments on policyholders.

In 1980 the recoupment statute was amended. St. 1980, c. 333: It is important to emphasize that on the threshold of that statute's enactment, *contractually* the JUA was bound to recoup, and the physicians-insureds, Petitioners here, were bound to pay, *only* by means of assessments on policyholders. That had been the JUA's choice, for whatever reason[s]. Originally, the JUA *could* have *contractually* agreed with its physicians-insureds, with Petitioners, that the JUA retained the broad statute-authorized powers to recoup by assessments, by prospective rate increased, or by both. But the JUA failed to do so.

The 1980 amendment ended the JUA's power to recoup by means of assessments. Categorically and unequivocally, the 1980 amendment *prohibited* the JUA from recouping deficits by means of assessments. This left the JUA in the position where although it was bound *contractually* to recoup deficits only by means of assessments on policyholders, *statutorily* the power to do so had been removed. The only statutory recoupment power which remained was prospective rate increases. In light of that, following the 1980 amendment the JUA could have altered its *subsequent* (post-1980) contracts/policies to conform to what was then the *only* statutory basis for deficit recoupment, prospective rate increases. But the JUA did not.

The consequence was that as to both old (pre-1980) and new (post-1980) contracts/policies the JUA had been placed by the legislation, and had impaled itself by its contracts/policies, on the horns of a dilemma: *it had been, and continued to be, committed contractually to recoup deficits only by means of assessments on policyholders, for which there was no longer any statutory authorization*. As to the JUA's *contractual* obligation to recoup and the physicians'-insureds' *contractual* obligation to pay that recoupment solely by means of assessments, there can be no doubt. The contracts/policies are quite clear on that point. As to the impact of the 1980 amendment on the JUA's power to recoup not by means of assessments but only via prospective rate increases, there is no doubt. The statute is quite clear on that point.

Where, then, did that leave the JUA?

Notwithstanding the express "recoupment via assessments on policyholders" term of its contracts/policies, and the resultant obligation of the physicians-insureds to pay deficit recoupment only via assessment, the JUA has actually recouped, and continues to seek recoupment, by means of prospective rate increases. While these prospective rate increases may be *statutorily* authorized, they are not *contractually* authorized.

In other words — and this is the core of Petitioners' Contract Clause claim — in substituting recoupment via prospective rate increase (as authorized by the 1980 statute) for recoupment via assessments (as contractually agreed to by the JUA and its physicians-insureds), *the JUA is using, and seeking to use, a statute (the 1980 amendment) to alter the contractual term of the physicians'-insureds' contracts/policies.* Put another way, the JUA is using a state statute to *impair the mutual obligation of Petitioners' contract/policies.*

Article I, § 10, of the Constitution of the United States prohibits any state from enacting a "law impairing the obligation of contracts." While it is true that the Contract Clause fell into disuse from the New Deal era through the period of the Warren Court,[4] in recent years there has been a revival. For example, *United States Trust Co.* v. *New Jersey*, 431 U.S. 1 (1977), involved a state-issued bond containing a covenant limiting the Port Authority from subsidizing passenger rail transportation from revenues and reserves. When the covenant was repealed, a lawsuit ensued based on the Contract Clause's guarantee against impairment. In invalidating the repeal as an unacceptable impairment of the bond's obligation, this Court drew a distinction that is important for the instant case. It recognized that when state interference with a *private* contract is challenged, as in *Blaisdell*, courts generally defer to the legislative judgment as to how necessary and reasonable a particular impairment actually is, just as courts customarily defer when reviewing economic and social legislation. However, when the state is *self-interested*, as it was in *United States Trust Co.* and as it is in the instant case, and when the state impairs its *own* obligations, as it has done here, less judicial deference is warranted than when the state interferes with private contracts. Thus, in *United States Trust*, this Court

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[4] *See, e.g., Home Building & Loan Ass'n* v. *Blaisdell*, 290 U.S. 398 (1934) and *El Paso* v. *Simmons*, 379 U.S. 497 (1965).

applied a *heightened standard of review*, insisting that a law impairing a state's own obligation must be "reasonable and necessary to serve an important public purpose." Here, the JUA's explanation for why it should be able to recoup deficits by means of prospective rate increases — because it needs the money — rather than continuing to be bound by its contractual obligation to recoup only via assessments presents the question of whether the JUA's interest sufficiently satisfies the constitutional heightened review standard for impairment of a contract. Moreover, it is not only the state which has an obligation under the insurance policies. So, too, do Petitioners and the other physicians-insureds. They have an obligation to pay for the recoupment of deficits, an obligation which is *contractually* limited to payment by means of an assessment. In this regard, *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234 (1978) is of interest. It is not so important that *Spannaus* involved a private, as opposed to a state's own, contract, as in *United States Trust Co.* Considerably more important in *Spannaus* is that this Court held there that the statute's imposition of *a new financial obligation* on employers violated the Contract Clause. Retroactive modification of voluntarily established pension benefit obligations was both "substantial" and "severe." This Court noted that the affected company had no reason to expect that its contractual obligations would be altered, and that it had relied heavily on what it understood its obligation to be in calculating its anticipated costs. Also significant was that the legislation had not been enacted to deal with a broad, generalized economic or social problem, or enacted to protect broad societal interests or deal with desperate emergency economic conditions. Nor did the law operate merely temporarily.

The *Spannaus* analysis, buttressed by *Energy Reserves Group, Inc.* v. *Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983), was reiterated by this Court not long ago. In *General*

Motors Corporation, et al. v. *Romein*, ___ U.S. ___, 112 S.Ct. 1105 (1992), Justice O'Connor wrote for a unanimous Court that in a Contract Clause analysis "[g]enerally, we first ask whether the change in state law has 'operated as a substantial impairment of a contractual relationship'. . . . This inquiry has three components: whether there is a contractual relationship, whether a change in law impairs that contractual relationship, and whether the impairment is substantial. Normally, the first two are unproblematic, and we need only address the third"[5] So, too, in the instant case. There was, and is, a contractual relationship between plaintiffs and the JUA. The statute did, and does, work an impairment of that relationship, as we stated *supra*: "In other words . . . in substituting recoupment via prospective rate increase (as authorized by the 1980 statute) for recoupment via assessments (as contractually agreed to by the JUA and its physicians-insureds), *the JUA is using, and seeking to use, a statute (the 1980 amendment) to alter the contractual term of the physicians'-insureds' contracts/policies*." Thus, the final question is whether that impairment is "substantial."

Here, when the JUA was created in 1975 Petitioners and other physicians in Massachusetts had a choice, of sorts. They could obtain medical malpractice insurance from "outside" sources, or they could sign up with the JUA, which is what most of them did. In doing so, they bargained for deficit recoupment by means of assessments "*upon the policyholders*." Since, in virtually the only definition provided by the 1975 legislation, a "policyholder" is defined as "all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not," the JUA-insured physicians bargained to be members of an identifiable, finite, pool of ratepayers who

[5] *Id.* at 1109, 1110.

collectively would be obligated to pay deficit recoupment. They did *not* bargain to be members of a potentially and/or actually different, and possibly even smaller pool of ratepayers who might exist when the JUA finally got around to levying a prospective rate increase. Yet that is the position in which they were put by the 1980 legislation, used by the JUA to impair its and Petitioners' obligations under the contracts/policies. No reasonable and necessary governmental end, calculated to serve an important public purpose (*United States Trust Co., supra*), has even been advanced to justify this impairment, let alone does one exist. As in *Spannaus, supra*, this new obligation is substantial and severe, the assessment-liable Petitioners had no reason to expect it, they relied on the explicit terms of their contracts/policies, and the JUA's use of prospective rate increases was neither emergency-based nor temporary. Whether this situation squares with the Contract Clause is a question presented by this Petition.

CONCLUSION

For the foregoing reasons, this Court should grant this Petition.

Respectfully submitted,

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October, 1994

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LIABILITY INVESTIGATIVE FUND EFFORT, INC., & others[1] *vs.* MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION & others[2] (and a companion case[3]).

Hampden. April 7, 1994. - July 21, 1994.

Present: LIACOS, C.J., ABRAMS, NOLAN, LYNCH, & GREANEY, JJ

Insurance, Medical malpractice insurance. *Statute*, Construction. *Constitutional Law*, Contracts clause, Separation of powers. *Due Process of Law*, Insurance regulation, Rate setting.

Article I, § 10, of the United States Constitution providing that "[n]o State shall . . . pass any . . . [l]aw impairing the [o]bligation of [c]ontracts," had no applicability to St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, providing for recoupment of deficits sustained by the Massachusetts Medical Professional Insurance Association by means of premium rate increases, where that statute's operation was prospective. [441-443]

Statute 1986, c. 351, enacted as a means to allow the Massachusetts Medical Professional Insurance Association to recover certain medical malpractice insurance premiums it lost as a result of a 1985-1986 rate freeze enacted by the Legislature was, as a legislative act, not subject to a procedural due process challenge; moreover, where that statute's operation affected only certain insurance policies whose premiums were expressly stated to be provisional, no considerations of due process barred retroactive redetermination of the premiums. [443-445]

Statute 1975, c. 362, § 6, as amended by St. 1980, c. 333, which provides for the recoupment of deficits sustained by the Massachusetts Medical Professional Insurance Association through premium rate increases and under which no deficit recoupment rates have yet been determined, does not violate due process by reason of the delay in its implementation inasmuch as those parties from whom recoupment may be sought did not show any confiscation or deprivation of property. [445-448]

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[1]Leonard Morse, Juan Penhos, Wayne Glazier, Francis Rockett, J. Gordon Rich, James Boyd, and E. Langdon Burwell, all of whom are physicians.

[2]Commissioner of Insurance and the Commonwealth.

[3]Robert S. Slocum *vs.* Massachusetts Medical Professional Insurance Association & others.

The provisions of St. 1986, c. 351, contain no requirement for a "plan of operation" for implementation, and this court declined to infer such a plan in interpreting the statute; accordingly a challenge to the statute for violation of the separation of powers doctrine in art. 30 of the Massachusetts Declaration of Rights, premised on such a requirement, had no merit. [448-449]

Ambiguity found in the provisions of St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333, with respect to the words "then in effect," as applicable to the "plan of operation" by which deficits sustained by the Massachusetts Medical Professional Insurance Association are recouped, was properly resolved so as to effectuate the Legislature's intent and to give the statute a constitutional construction; thus, recoupment is governed by the plan of operation in effect at the time of recoupment, not at the time the deficits are accrued: accordingly, because there is now a plan of operation in effect, recoupment under that plan will not violate the separation of powers doctrine of art. 30 of the Massachusetts Declaration of Rights. [449-450]

CIVIL ACTIONS commenced in the Superior Court Department on June 2, 1988, and May 3, 1989, respectively.

The cases were heard by *Richard F. Connon*, J., on motions for summary judgment.

The Supreme Judicial Court granted a request for direct appellate review.

Henry Mark Holzer, of New York, for Liability Investigative Fund Effort, Inc., & others.

Michael J. Lacek for Massachusetts Medical Professional Insurance Association.

Eric A. Smith, Assistant Attorney General, for Commissioner of Insurance & another.

GREANEY, J. In these consolidated cases, the corporate plaintiff and the individual plaintiffs, on behalf of themselves and others similarly situated, bring constitutional challenges to two statutes relating to the provision of medical malpractice insurance by the Massachusetts Medical Professional Insurance Association (MMPIA). Both St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, and St. 1986, c. 351, provide for payments by malpractice insureds for costs incurred by the MMPIA in providing malpractice insurance in past

years. The complaints sought declaratory and other relief to challenge the statutes as violations of the contracts clause of the United States Constitution, Federal and State guarantees of procedural due process, and the separation of power requirements of art. 30 of the Declaration of Rights to the Massachusetts Constitution. Both the plaintiffs and the defendants moved for summary judgment. See Mass. R. Civ. P. 56 (a), (b), 365 Mass. 824 (1974). A judge of the Superior Court denied the plaintiffs' motion and granted the defendants' motions in a well-reasoned memorandum of decision. We granted the plaintiffs' application for direct appellate review and now affirm.

We first set forth the undisputed facts. In 1975, "to guarantee the continued availability of medical malpractice insurance" in the Commonwealth, the Legislature enacted St. 1975, c. 362, of which § 6 established the Medical Malpractice Joint Underwriting Association of Massachusetts, which is now the MMPIA. The MMPIA was authorized to issue malpractice insurance policies to physicians and hospitals that "[have] made a reasonable effort to obtain insurance and [have] been unable to obtain it." St. 1975, c. 362, § 6, fifth par. The statute stated that the MMPIA's purpose was to provide this insurance "on a self-supporting basis." St. 1975, c. 362, § 6, second par. Toward that end, both the original statute creating the MMPIA and a later statute, St. 1986, c. 351, have provided for the collection by the MMPIA of funds for past, underfunded insurance periods. It is the validity of those two statutes that the plaintiffs challenge here.

The challenged portion of St. 1975, c. 362, § 6, which we will refer to as the deficit recoupment statute, provided as follows:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by [an assessment upon the policyholders, or] a rate increase applicable prospectively [, or both]; provided, however, that in no

> event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term 'policyholders' shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through [MMPIA] or not."

St. 1975, c. 362, § 6, seventh par. This paragraph was subsequently repealed and reenacted without the bracketed language. St. 1980, c. 333. During the first dozen years of its operation, the MMPIA did not seek to recoup any deficits under this statute.

In 1987, however, the MMPIA filed a request to begin recouping deficits that accrued in the years 1975-1982. A hearing officer of the Division of Insurance, and subsequently the Commissioner of Insurance (commissioner), determined that if recoupment were ordered, it would be made from all physicians and hospitals, regardless of whether they were insured by the MMPIA. That decision was challenged and affirmed in *Risk Management Found. of Harvard Medical Insts., Inc.* v. *Commissioner of Ins.*, 407 Mass. 498, 503-505 (1990). Subsequently, on February 25, 1991, the parties to that case entered into a stipulation that no requests for recoupment would be made before April 1, 1993. To the present time, no specific determination has been made regarding the MMPIA's deficits, and no rate increase has been established.

The second statute at issue is St. 1986, c. 351, which we will refer to as the deferred premium liability statute. This statute was the eventual result of the MMPIA's recommendation of a 162.7% increase in its premium rates for its 1983 rate year. The commissioner rejected that recommendation and instead allowed only a 42% increase. The MMPIA appealed, and we determined that the commissioner had misinterpreted the applicable statutes, so we ordered further

ratemaking proceedings. *Medical Malpractice Joint Underwriting Ass'n of Mass.* v. *Commissioner of Ins.*, 395 Mass. 43 (1985). The Legislature then froze premium rates at the level of the commissioner's overturned decision. St. 1985, c. 671, § 1. It later extended the freeze to July 1, 1986. St. 1986, c. 37.

On June 6, 1986, the commissioner issued a new decision, raising the 1983 rate 93.9% above the previous year's rate, and raising the 1984 rate 10.9% above the 1983 rate. No appeal was taken from those rate decisions. Later that month the Legislature enacted the deferred premium liability statute as a means to allow the MMPIA to recover premiums it lost as a result of the legislative rate freeze. The operation of the statute was described as follows in a previous decision in this case:

> "The statute established a 'total deferred premium liability,' which is a sum representing the difference between the rates set by the commissioner pursuant to c. 175A, § 5A, for the 1983-1985 rate years and the premiums actually paid for the period pursuant to the freeze. The statute provided for recovery of the total deferred premium liability over a five-year period from July 1, 1987, through June 30, 1992, by means of a 'separate rate' added to the normal rate for policies issued during that period. The separate rates were to be assessed and recovered in the same manner as rates established pursuant to c. 175A, § 5A. See St. 1986, c. 351, § 38. The statute did not refer to the deficit recoupment provision of St. 1975, c. 362, § 6, 7th par., discussed above."

Liability Investigative Fund Effort, Inc. v. *Medical Malpractice Joint Underwriting Ass'n of Mass.*, 409 Mass. 734, 738-739 (1991).

The plaintiffs challenge the deficit recoupment statute and the deferred premium liability statute on three grounds. First, they argue that the 1980 amendment of the deficit re-

coupment statute violates the contracts clause of the United States Constitution.[4] Second, they contend that the provisions of both statutes for the recovery of funds for past policy periods violate both State and Federal guarantees of procedural due process. Third, they argue that some of the MMPIA's actions under the statutes were taken without having in place the "plan of operation" provided for by St. 1975, c. 362, § 6, and that in the absence of such a plan those actions violate the separation of powers provisions of art. 30 of the Declaration of Rights. We address each of these arguments in turn.

1. The plaintiffs' first argument is that the malpractice insurance policies issued by the MMPIA in 1975-1982, the period for which it seeks recoupment, committed it to contractual obligations that are inconsistent with St. 1980, c. 333. The specific contractual provisions on which the plaintiffs rely are exemplified by the following language in a policy endorsement from 1977: "Any deficit sustained by the [MMPIA] in any one year shall be recouped by an assessment upon all medical malpractice insurance policyholders, whether insured through the [MMPIA] or otherwise." In

[4]In their reply brief, the plaintiffs also argue that the deferred premium liability statute violates the contracts clause. This argument, however, was neither considered by the trial judge nor argued by the plaintiffs in their initial brief on appeal, where they challenged only the "prospective rate increases" of St. 1980, c. 333. We therefore need not consider this new argument here. See Mass. R. A. P. 16 (a) (2), 365 Mass. 860 (1974), and 16 (a) (4), as amended, 367 Mass. 921 (1975).

In any event, as is described below in the context of the plaintiffs' due process argument, the plaintiffs' policy agreements with the MMPIA for the years subject to deferred premium liability described the rates for those policies as "provisional." Revision of those rates is therefore not an impairment of contract. See *Weaver* v. *Graham*, 450 U.S. 24, 29-30 (1981) ("Evaluating whether a right has vested is important for claims under the Contracts or Due Process Clauses, which solely protect pre-existing entitlements"); *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 39-40 (1972) ("[W]e conclude that no unconstitutional . . . impairment of contract will be involved in an adjustment for excessive 1971 premiums, because the rates set for 1971 compulsory insurance were provisional and subject to change, and thus did not become the property of the companies").

light of such provisions, the plaintiffs argue, "an essential term of [the MMPIA] contracts/policies was the method by which, and the pool from which, the [MMPIA] would collect, and the insureds would pay, deficits which might later be recouped"; the contracted-for method was assessment, and the "pool" was the class of policyholders existing at the time the deficits accrued. Therefore, the argument continues, the 1980 amendment providing for recoupment only "by a rate increase applicable prospectively," and the MMPIA's proposal to recoup deficits under that amendment, are inconsistent with the MMPIA's contractual limitation to recoupment by assessment and with the commitment to recoupment from the class of policyholders existing at the time of the contracts. This, the plaintiffs say, violates art. I, § 10, of the United States Constitution, which provides that "[n]o State shall . . . pass any . . . [l]aw impairing the [o]bligation of [c]ontracts."

Resolution of the plaintiffs' claim is straightforward in light of the provision in St. 1980, c. 333, for "a rate increase applicable *prospectively*" (emphasis added). The contracts clause "applies only to laws with retrospective, not prospective, effect." *Local Div. 589, Amalgamated Transit Union* v. *Commonwealth*, 666 F.2d 618, 637 (1st Cir. 1981) (citing *Ogden* v. *Saunders*, 25 U.S. [12 Wheat.] 213 [1827]), cert. denied, 457 U.S. 1117 (1982). Hence, the clause is inapplicable here. It cannot be the case that by entering into its insurance policies the MMPIA restricted the Legislature's ability to authorize any future deficit recoupment method not specified in the policies.

The plaintiffs simply fail to distinguish between actions taken by the MMPIA under its existing contracts with policyholders and actions taken by the Legislature and the MMPIA regarding the terms of the MMPIA's future contracts. The deficit recoupment statute, St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, specifically provides that the "policyholders" subject to prospective rate increases are "all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through

[MMPIA] or not." Because the statute thus applies the rate increase to malpractice insureds regardless of whether they have had any contractual relationship with the MMPIA, it is clear that the application of that increase cannot be part of past MMPIA contracts. In fact, the plaintiffs will not themselves be subject to any eventual rate increases under the deficit recoupment statute if they are not insured under malpractice policies in Massachusetts at the time such increases are imposed. See *Risk Management Found.*, *supra* at 505 ("Recoupment liability under c. 333 is one of the many conditions of licensure which the Legislature through its police power may impose on doctors and hospitals").

2. The plaintiffs' second argument is that both St. 1975, c. 362, the deficit recoupment statute, and St. 1986, c. 351, the deferred premium liability statute, violate the procedural due process guarantees of the Federal and State Constitutions. With regard to both statutes, the plaintiffs argue that due process has been violated by "[t]he Commonwealth's undisputed delay in assessing, and in seeking to assess[,] retroactive premiums to collect these deficits."[8] Because the two statutes function differently, we will consider each separately.

We observe preliminarily that we have treated the procedural due process protections of the Massachusetts and United States Constitutions identically. See, e.g., *Allen* v. *Assessors of Granby*, 387 Mass. 117, 119 (1982); *Lotto* v. *Commonwealth*, 369 Mass. 775, 776-777 (1976). In the present case, where the plaintiffs claim that a denial of procedural due process deprived them of property, they must show first that the property interest that they claim was one to which they had an entitlement. See *Regents of State Colleges* v. *Roth*, 408 U.S. 564, 577 (1972); *Allen* v. *Assessors of Granby*, *supra* at 119. Only if the plaintiffs make such a showing do we need to consider whether the procedures used

[8]We need not resolve the parties' heated dispute over whether the effect of the deferred premium liability statute is "really" deficit recoupment. We will consider the operation of the two statutes without relying on the labels applied to them.

meet the requirements of due process. *Lotto* v. *Commonwealth*, *supra* at 777.

a. The plaintiffs' challenge to the validity of the deferred premium liability statute, St. 1986, c. 351, is subject to several responses. First, although the plaintiffs characterize their challenge as one to the delay created by the statute, it is clear that their challenge is to the Legislature's decisions themselves. The delay in assessing the premiums was expressly imposed by the Legislature in St. 1985, c. 671, and extended in St. 1986, c. 37, and collection of the delayed (deferred) premiums was expressly authorized in St. 1986, c. 351. In general, neither State nor Federal legislative acts are subject to procedural due process challenges. See *Martinez* v. *California*, 444 U.S. 277 (1980); *Bi-Metallic Inv. Co.* v. *State Bd. of Equalization*, 239 U.S. 441, 445-446 (1915). The rationale for this rule is that, regardless of whether a protected property interest is at stake, "the legislative determination provides all the process that is due." *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982). The rule applies specifically to legislative changes in benefits. *Atkins* v. *Parker*, 472 U.S. 115, 129 (1985). Such changes are subject to substantive due process challenge, *id.* ("Such a change must, of course, comply with the substantive limitations on the power of Congress . . . ."), but the plaintiffs here have stipulated to the dismissal of their counts raising such substantive challenges. Hence, their reliance on a procedural challenge is misplaced.

Moreover, the property interest that the plaintiffs claim is in insurance rates that were specifically denoted on the policies as "provisional." The deferred premium liability statute applies to "policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six." St. 1986, c. 351, § 38 (1). The policies in the record that were issued in this period all state explicitly that the rates charged in those policies are "provisional."[8]

[8]The policy issued to plaintiff Leonard J. Morse on December 13, 1983, contains the following statement: "These rates are provisional and may be

We have previously rejected a challenge to a retroactive reduction in insurance rates where those rates "were provisional and subject to change, and thus did not become the property of the [insurance] companies." *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 40 (1972). Although the claims rejected in that decision were only takings and impairment-of-contract claims, the same result applies more generally to the due process claims of the plaintiffs here.[7] See *Murphy Nursing Home, Inc.* v. *Rate Setting Comm'n*, 364 Mass. 454, 459 (1973) ("The Constitution of the United States interposes no barrier to retroactive redetermination of provisional or tentative rates," citing *Great N. Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 362 [1932]), appeal dismissed, 417 U.S. 962 (1974). The deferred premium liability statute does not violate procedural due process.

b. The deficit recoupment statute, unlike the deferred premium liability statute, does not provide expressly for the time at which the statute is to operate. Hence, with regard to the deficit recoupment statute, the plaintiffs can properly argue that "the *delay* in utilizing the existing statute is what violated due process." However, the plaintiffs cite no case that would support a procedural due process claim in these circumstances. Although they cite cases that have accepted challenges to delays, all of those cases involved deprivations of property, either through delays in ending confiscatory

adjusted when 1983 rates and class levels are published." The policies issued to Morse on December 11, 1984, and December 12, 1985, both stated that "the premiums stated in the declarations are provisional and are subject to recomputation if the rates fixed and established by the Commissioner of Insurance for use in connection with this policyare [*sic*] revised by order of the Supreme Judicial Court or the Commssioner [*sic*] of Insurance." The latter language is substantially similar to that cited in *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 362 Mass. 34, 40 (1972).

[7]The fact that the plaintiffs here are insureds, whereas in *Employers' Commercial Union* they were insurers, is also not significant. The policies provide notice of the provisional nature of the rates to both insurer and insured.

rates or delays in implementing increased benefits decisions.[8] See *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587, 591 (1926) ("Property may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them"); *MCI Telecommunications Corp.* v. *FCC*, 627 F.2d 322, 341 (D.C. Cir. 1980) ("delay in the resolution of administrative proceedings can . . . deprive regulated entities, their competitors or the public of rights and economic opportunities without the due process the Constitution requires"); *Perez* v. *Lavine*, 378 F. Supp. 1390, 1394-1395 (S.D.N.Y. 1974) ("delay in the delivery of benefits" raises a substantial constitutional question); *Nelson* v. *Sugarman*, 361 F. Supp. 1132, 1134 (S.D.N.Y. 1972) (finding constitutional violation in State's "fail[ure] to implement in timely fashion fair hearing decisions which had upheld their right to increased benefits"). The plaintiffs in effect acknowledge that success of their challenge requires that there have been a deprivation of property, because they argue that, by means of the delay, the MMPIA has imposed "insurance premiums which are so excessive as to be confiscatory."[9] But the delay in deficit recoupment did not result in a confiscation of the plaintiffs' property; instead, by delaying collection, it allowed them to retain for a longer time amounts determined by statute to be due.[10] The only way in which the plaintiffs argue that they were deprived of property due to the delay is that "a sub-

[8]An exception is *Railroad Retirement Bd.* v. *Alton R.R.*, 295 U.S. 330 (1935). In that case, however, no issue of procedural due process was raised; the challenged statute was instead held to be a taking. See *id.* at 350 ("Thus the Act denies due process of law by taking the property of one and bestowing it upon another"). In the present case the plaintiffs have stipulated to the dismissal of their takings claims.

[9]The plaintiffs also argue that due process has been violated by MMPIA's imposition of the deficit recoupment rates "retroactively." However, as we concluded in the discussion of the plaintiffs' contract clause claims, the deficit recoupment statute is not retroactive.

[10]The plaintiffs do not argue in this appeal that the rates charged by the MMPIA, either originally or with the yet-to-be-determined prospective rate increases, are in themselves confiscatory; they argue only that the delay resulted in confiscation of their property.

stantial new financial obligation has been added because there is a potentially smaller ratepayer base available to pay the prospective rate increases."[11] However, they offer no evidence of the relative numbers of policyholders in 1975-1982, and the present, so this claim is purely speculative, and they have raised no genuine issue of fact. See Mass. R. Civ. P. 56 (c), 365 Mass. 824 (1974).

The plaintiffs point to one of our previous decisions, *Workers' Compensation Rating & Inspection Bureau* v. *Commissioner of Ins.*, 391 Mass. 238, 269 (1984), as support for their argument. Although that case denied the plaintiffs' claims of a violation of due process, it said that "[u]njustified delays in acting on proposed rates may in some circumstances constitute a denial of procedural due process." *Id.* at 269. However, the cases cited by the *Workers' Compensation Rating & Inspection Bureau* decision make clear that those circumstances are not present here. In one of the cases cited, *Boston Gas Co.* v. *Department of Pub. Utils.*, 368 Mass. 51 (1975), we found a violation of procedural due process where the administrative agency involved had failed to provide a hearing regarding a delay in instituting new rates. *Id.* at 54-55. In the present case, however, the plaintiffs do not challenge the process used to determine deficit recoupment rates; indeed, no deficit recoupment rates have yet been determined. Instead, they challenge the fact of the MMPIA's de-

[11]The plaintiffs do argue that, because any eventual deficit recoupment will occur after the time at which the deficits accrued, they will be unable to pass on the costs of deficit recoupment to their patients of that earlier time. However, that result is a consequence of the legislative decision to effect deficit recoupment through prospective rate increases applied to policyholders at the time of recoupment, rather than to those who were policyholders at the time the deficits accrued; it would be the case regardless of the delay in deficit recoupment.

The plaintiffs also claim that the very existence of deficit recoupment, which requires policyholders collectively to eventually pay all the costs of their malpractice claims, means that they were deprived of an interest "in purchasing real insurance and in getting the value of what they have bought." Insurance, however, involves not just the shifting of risk from insured to insurer, but also risk-sharing among insureds. The fact that the MMPIA will not suffer losses does not deprive the plaintiffs of insurance.

lay in seeking the deficit recoupment. Such a challenge is not supported by *Boston Gas*, which mentioned a constitutional problem as the result of delay itself only where "there has been confiscation of . . . property as a result of agency action." *Id.* at 54.[12] Here, as described above, the plaintiffs have shown no confiscation, and have therefore shown no violation of due process.

3. The plaintiffs' final claim is that the MMPIA has not complied with the requirements in St. 1975, c. 362, § 6, that the MMPIA have in place a "plan of operation." The plaintiffs point to the statute's direction that "[t]he commissioner shall, after consultation with the [MMPIA] . . . and other affected individuals and organizations promulgate a plan of operation," St. 1975, c. 362, § 6, fourth par., and to the following portion of the deficit recoupment statute:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by a rate increase applicable prospectively . . . ."

St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333. It is undisputed that the commissioner promulgated a plan of operation effective June 27, 1975, but that the plan terminated by its own terms on December 31, 1977. A new plan was promulgated on June 15, 1991.

The plaintiffs therefore allege that there was no plan of operation in place between January 1, 1978, and June 15, 1991. They argue that any actions taken by the MMPIA in the absence of such a plan are invalid as a violation of the doctrine of separation of powers in art. 30 of the Declaration

[12]The other two cases cited by the *Workers' Compensation Rating & Inspection Bureau* decision are to the same effect. *Warner Cable of Mass., Inc.* v. *Community Antenna Television Comm'n*, 372 Mass. 495 (1977), relies on *Boston Gas Co.* v. *Department of Pub. Utils.*, 368 Mass. 51 (1975), and *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587 (1926), is discussed above.

of Rights.[13] As with their procedural due process claim, the plaintiffs argue that the absence of a plan of operation invalidates actions taken under both the deferred premium liability and deficit recoupment statutes, and we discuss each statute separately.

a. The plaintiffs do not argue that the deferred premium liability statute, St. 1986, c. 351, itself requires a plan of operation. They argue instead that a plan of operation is necessary because "deferred premium liability is merely deficit recoupment under a different name," and that it therefore requires a plan of operation as provided in the deficit recoupment statute. However, regardless of what deferred premium liability really "is," we must interpret the deferred premium liability statute as it is written. The plaintiffs point to no reference to a "plan of operation" in St. 1986, c. 351, or in either St. 1985, c. 671, or St. 1986, c. 37, the two statutes that imposed the deferral of the eventual rate increases. On the contrary, St. 1986, c. 351, itself provides in detail the terms for the recovery of deferred premium liability. The statute directs the commissioner to calculate "separate rates" to be collected in equal amounts in the four rate years from July 1, 1987, to June 30, 1991, and states that the separate rates "may be assessed and recovered with respect to policies of medical malpractice insurance issued during said periods by the [MMPIA] in the same manner as rates established pursuant to [G. L. c. 175A, § 5A] are assessed and recovered." St. 1986, c. 351, § 38 (3). These provisions describe the means for collecting deferred premiums, they impose no requirement of a plan of operation, and we will not infer one.

[13]Article 30 provides:

> "In the government of this commonwealth, the legislative department shall never exercise the executive and judicial powers, or either of them: the executive shall never exercise the legislative and judicial powers, or either of them: the judicial shall never exercise the legislative and executive powers, or either of them: to the end it may be a government of laws and not of men."

b. As described above, the deficit recoupment statute provides in relevant part:

> "Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan *then in effect* by a rate increase applicable prospectively . . . " (emphasis added).

St. 1975, c. 362, § 6, seventh par., as amended by St. 1980, c. 333. The plaintiffs argue that the emphasized language requires that the MMPIA recoup deficits by applying the plan of operation in effect at the time the deficits accrued. The judge, however, "decline[d] to read the language in that manner and conclude[d] that another reasonable interpretation of the statute would read this same language as requiring the [MMPIA] to employ the plan in effect at the time of recoupment." Although we recognize that the statute as written is ambiguous, we think that the judge's interpretation is the more sensible.

As described above, the operation of the deficit recoupment statute is purely prospective, so it would be anachronistic for the terms of that recoupment to be governed by past plans of operation. Recoupment will be made from those who are medical malpractice policyholders at the time of the recoupment, not at the time the deficits are accrued, as described above, and it would be unreasonable to require the MMPIA, and policyholders, to refer to past plans of operation to determine the method of recoupment. Moreover, such an interpretation would introduce needless complication if the plans for past years differed and, as here, deficits were to be recouped for several different years. We conclude that the better reading of the statute is that deficit recoupment is to be governed by the plan of operation in place at the time of the recoupment. This construction effectuates the Legislature's intent, see *James J. Welch & Co.* v. *Deputy Comm'r of Capital Planning & Operations*, 387 Mass. 662, 666 (1982), and gives the statute a constitutional construction, see *Ferguson* v. *Commissioner of Corps. & Taxation*, 316

Mass. 318, 322-324 (1944). Because there is now a plan of operation in effect, recoupment under that plan will not violate the separation of powers provision of art. 30.

4. In sum, neither the deficit recoupment statute, St. 1975, c. 362, § 6, as amended by St. 1980, c. 333, nor the deferred premium liability statute, St. 1986, c. 351, violates the contracts clause of the United States Constitution, State or Federal guarantees of procedural due process, or the separation of powers requirements of art. 30 of the Declaration of Rights. The amended summary judgment and the amended partial summary judgment, both entered on July 30, 1993, are affirmed.

So ordered.

SECTION 36. Said section 6 of said chapter 362 is hereby further amended by adding the following paragraph:-

Effective January first, nineteen hundred and eighty-seven, the commissioner is authorized to establish a system of surcharges and credits for all physicians insured by the association. Said system shall provide for surcharges to be imposed on all physicians insured by the association whose claims in the previous five years exceed in number the average number of claims asserted against physicians in their specialty. Such surcharges each year for a physician shall be calculated on an actuarially sound basis to reflect the increased cost of defending physicians with more claims asserted against them than the average in their specialty. A physician who does not renew his policy with the association for any year will not be liable for any surcharges for the year of nonrenewal, except that a physician who would otherwise be liable for a surcharge and purchases from the association coverage for occurrences which took place during a period in which he was covered under a claims-made policy may be charged in the premium for such additional coverage a surcharge calculated on an actuarially sound basis. Said system shall further provide for credits to be given to all physicians insured by the association who have not had a civil action commenced against them for malpractice, error or mistake in the provision or failure to provide medical or surgical services during their practice in the commonwealth over a time period which the commissioner by regulation shall determine. The credit or credits will be calculated by specialty on an actuarially sound basis to reflect any decreased likelihood of such physicians incurring liability for claims for which the association will be liable.

SECTION 37. Said chapter 362 is hereby further amended by striking out section 13, as most recently amended by chapter 650 of the acts of 1985, and inserting in place thereof the following section:-

Section 13. Sections four, six and twelve of this act shall take effect upon their passage, and all other sections of this act shall take effect on January first, nineteen hundred and seventy-six. Section six of this act shall terminate on July first, nineteen hundred and ninety-two.

SECTION 38. (1) As used in this section, the following terms shall have the following meanings:-

"Total deferred premium liability", an amount equal to the difference between the amount of premium charges payable with respect to all policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for physicians in the commonwealth insured by the medical malpractice joint underwriting association, created pursuant to section six of chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five, as finally established with respect to such policies pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, and the amount of premium charges which were payable with respect to such policies during said period, as established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four.

"Individual deferred premium liability", an amount equal to the difference between the amount of premium charges payable with respect to policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for an individual physician in the commonwealth insured by the medical malpractice joint underwriting association, as finally established with respect to such policies pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, and the amount of premium charges which were payable with respect to such policies during said period, as established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four.

(2) Notwithstanding any general or special law to the contrary, with respect to policies issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for medical malpractice insurance for physicians in the commonwealth insured by the medical malpractice joint underwriting association, no premium charges shall be recovered, except as provided in paragraph (4) of this section, prior to July first, nineteen hundred and eighty-seven in excess of the premium charges established by the commissioner of insurance in his decision dated May eighteenth, nineteen hundred and eighty-four. Nothing contained in this section shall be construed to prevent or interfere with the final establishment of premium charges with respect to such policies by the commissioner of insurance pursuant to the provisions of section five A of chapter one hundred and seventy-five A of the General Laws, provided that the total deferred premium liability or any individual deferred premium liability accruing with respect to such policies shall be recovered only in accordance with the provisions of paragraphs (3) and (4), respectively, of this section.

(3) Commencing on July first, nineteen hundred and eighty-seven, the total deferred premium liability shall be recovered by the joint underwriting association as follows. The commissioner of insurance shall annually determine the portion of the total deferred premium liability then outstanding which is attributable to each risk classification of premium charges for policies of medical malpractice insurance. In making such determinations, the commissioner shall attribute to each such classification that portion of the total deferred premium liability then outstanding which accrued with respect to policies of medical malpractice insurance issued on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six for physicians engaging in the practice or specialty included in such classification as of the date of such determination. In making such determination, the commissioner shall also deduct from the portion of the total deferred premium liability then outstanding which would otherwise be attributable to each such classification any amounts of individual deferred premium liability which have been recovered pursuant to paragraph (4) of this section. With respect to policies of medical malpractice insurance issued by the joint underwriting association on or after July first, nineteen hundred and eighty-seven and before July first, nineteen hundred and ninety-two, the commissioner

shall, in addition to the rates established for such policies pursuant to section five A of chapter one hundred and seventy-five A of the General Laws, establish a separate rate for each risk classification which shall be sufficient to permit the recovery by the association of the following amounts, plus interest on the amount then outstanding calculated at the rate of eleven per cent per year, commencing as of July first, nineteen hundred and eighty-seven: twenty per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-seven for each such classification, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-seven and before July first, nineteen hundred and eighty-eight; twenty-five per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-eight for each such classification, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-eight and before July first, nineteen hundred and eighty-nine; thirty-three and one-third per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and eighty-nine, such rate to apply to policies issued on or after July first, nineteen hundred and eighty-nine and before July first, nineteen hundred and ninety; fifty per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and ninety, such rate to apply to policies issued on or after July first, nineteen hundred and ninety and before July first, nineteen hundred and ninety-one; and one hundred per cent of the total deferred premium liability outstanding as of July first, nineteen hundred and ninety-one, such rate to apply to policies issued on or after July first, nineteen hundred and ninety-one and before July first, nineteen hundred and ninety-two. Such separate rates may be assessed and recovered with respect to policies of medical malpractice insurance issued during said periods by the Joint Underwriting Association in the same manner as rates established pursuant to section five A of chapter one hundred and seventy-five A of the General Laws are assessed and recovered.

(4) Notwithstanding the provisions of paragraph (2) of this section, any physician who was covered by a policy of medical malpractice insurance issued by the Joint Underwriting Association on or after July first, nineteen hundred and eighty-three and before July first, nineteen hundred and eighty-six and who ceases to practice medicine in the commonwealth, unless such cessation is caused by the death of the physician, the retirement of the physician due to disability or after attainment of age sixty-five, or the relocation of the physician outside of the commonwealth immediately upon completion of a residency or internship, shall be liable as of the date of such cessation of practice for the amount of individual deferred premium liability which has accrued with respect to such policies; provided that if such cessation of practice occurs after July first, nineteen hundred and eighty-seven, said individual deferred premium liability shall be reduced by the amount of total deferred premium liability recovered from said physician pursuant to paragraph (3) of this section. The joint underwriting association shall report to the commissioner of insurance no later than April first of each year, commencing in nineteen hundred and eighty-seven and

until nineteen hundred and ninety-one, of the amounts recovered from physicians in each risk classification who are subject to recovery of individual deferred premium liability pursuant to this paragraph. Failure by the association to report any amount recovered from a physician pursuant to this paragraph shall constitute an unfair and deceptive insurance act punishable under chapter one hundred and seventy-six D of the General Laws; provided that each such failure to report shall constitute a separate act or practice for the purpose of imposition of penalty under that chapter.

SECTION 39. The special commission on medical malpractice established in chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five is hereby authorized and directed to conduct an investigation and study of the legal, tax, reimbursement, and regulatory status of nonprofit hospital service corporations and nonprofit medical service corporations, as established pursuant to chapters one hundred and seventy-six A and one hundred and seventy-six B of the General Laws. Said study shall also include a review of the standing of said corporations in relationship to other health care insurers and nonprofit medical service corporations within and without the commonwealth, to government programs of health insurance and to competing and alternative forms of health care financing. Particular attention shall be paid to the corporations' rights to contract with professional and other noninstitutional providers of health care services, the system of payments made by said corporation, including the impact of the prohibition on the practice of balance billing, so-called, the process by which the fees paid by said corporations to participating physicians are set, the extent to which said fees are reflective of the costs of providing medical services, including but not limited to, the cost of medical malpractice premiums, the adequacy and efficacy of existing dispute resolution mechanisms available to said corporations and professional providers, the financial and accounting procedures of said corporations and their impact on the quality and cost of health care services.

Said commission is further directed to conduct an investigation and study into the feasibility of establishing a patient compensation fund, so-called. Said study shall include a review of the operation of such funds in other states, an analysis of various funding mechanisms, and an estimate of the administrative cost of such a fund and its potential impact on medical malpractice premiums.

Said commission is further directed to conduct an investigation and study relative to the viability of a system which would provide for early tender of compensation to victims of medical malpractice, the economic ramifications of such a system upon such victims, the potential effect such a system might have upon premiums for medical malpractice insurance, the ability of the joint underwriting association to administer a system of early tender of compensation, a comparison of an early tender system of compensation to the existing medical malpractice procedure, the question of whether or not a system of early tender of compensation would have a negative effect on the ability of this commonwealth to effectively oversee and, where necessary, to discipline